PATIENT INFORMATION FORM

Welcome to Carn-Brae Clinic. We require you to provide us with your personal details and a full medical history so that we may appropriately assess, diagnose and treat illnesses and medical conditions, ensuring we are proactive in your health care.

Annual Membership Fee

All New and existing patients 18 years and over are required to pay the yearly Membership Fee of $66.00
Members will receive an Annual Free Skin Check in addition to many Services for Free or at a reduced cost. This payment is due on the first consultation of each year and can be paid at reception. Payments can also be paid over the phone anytime for your convenience. Please ask reception for a Membership Flyer showing all the benefits.

100% BULK BILLING for all Patients with a current Medicare Card for all GP consultations
Some procedures and services may incur a fee.

RESULTS
Patients are required to have an appointment with their doctor to receive their results either by phone or in person, and in accordance with our Recall Policy and Procedures.

PRIVACY POLICY
In accordance with the Privacy Act, all information collected in this practice is treated as confidential. To protect your privacy, this practice operates in accordance with this Act. A copy of our privacy policy is available at reception upon request.

MY HEALTH RECORD
You give permission for your Doctor to upload to your My Health Record.

If you do not consent to the participation in My Health Record please tick this box ☐

PATIENT CONSENT

I, _____ give permission for my personal information to be collected, used and disclosed by the practice for the following purposes:

- Administrative purposes in the operation of our general practice.
- Follow up reminder/recall notices for treatment and preventative healthcare, frequently issued by SMS.
- Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following the referrals.
- Accreditation and quality assurance activities to improve individual community health care and practice management.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de-identified information is used.
- To comply with any legislative or regulatory requirements, e.g. notifiable diseases.
- For use when seeking treatment by other doctors in this practice.

I have read and understood all the above information.

Patient/Guardian Signature: _____

Date: _____

Patient Details - Please fill in all the requested information and ensure that an Emergency / Next of Kin name and contact number is included this is important.

Surname Mr. /Mrs./Ms./Master/Miss

_____

First Name _____

Date of Birth _____ **Sex at Birth** _____

Pronouns _____ **Gender Identity** _____

Address: _____

Patient Phone number _____

Height _____ **Weight** _____ **Waist cm** _____

Medicare Card Number _____ **Ref** ___ **Expiry** _____

Concession Card P/s note type _____

CRN Number _____ **Expiry** _____

Vet Affair Type _____ **Number** _____ **Expiry** _____

Next of Kin or Emergency Contact Name _____

Relationship to you _____ **Phone Number** _____

ATSI – Are you? p/s circle - Aboriginal Yes / No **Torres Strait Islander** Yes / No **Neither**

Country of Birth _____ **Yr. of Arrival in Australia** _____

Ethnicity _____ **Spoken Language** _____

Interpreter required Yes /No

😊 **Please tell us how you heard about Carn Brae Clinic by ticking a box below**

☐ Website ☐ Facebook ☐ Google ☐ Friend ☐ Family ☐ Word of Mouth ☐ Other

Thank you for taking the time to fill out our Patient Information Form
We would love to hear your feedback
Please follow us on
Facebook or Google Review Us

ALLERGIES / SENSITIVITIES	**YES**	**NO**	**Specify…**

DIET / LIFESTYLE	**YES**	**NO**	**Specify…**
Drink Alcohol	□	□	_____
Other Drugs	□	□	_____
Smoker p/s circle	Yes	No	

Current Medications

Medication Name	Strength	Dosage	Frequency

Previous Operation /Procedure

_____
_____
_____
_____
_____
_____
_____
_____
_____

Past Medical History

ONCOLOGY	**YES**	**NO**	**Specify…**	**Family History □**
Do you have Cancer?	□	□	_____	

TREATMENT	**YES**	**NO**	**Specify…**
Surgical Removal of Cancer	□	□	_____
Radiotherapy /	□	□	Last Radiotherapy: ___ / ___ / _____
Chemotherapy			Last Chemotherapy: ___ / ___ / _____
Pharmacological Treatment	□	□	_____
Palliative	□	□	_____

NEUROLOGICAL	**YES**	**NO**	**Specify…**	**Family History ☐**
CVA / TIA	☐	☐	_____	
Parkinson's Disease	☐	☐	_____	
Epilepsy / Seizures	☐	☐	_____	
Migraines / Headaches	☐	☐	_____	
Sleeping Problems	☐	☐	_____	
Chronic Pain	☐	☐	_____	
Dementia / Memory Loss	☐	☐	_____	

CARDIOVASCULAR	**YES**	**NO**	**Specify…**	**Family History ☐**
Angina / Chest Pain / AMI	☐	☐	_____	
Hypertension / Hypotension	☐	☐	_____	
High Cholesterol	☐	☐	_____	
Thromboembolism	☐	☐	_____	
Rheumatic Fever	☐	☐	_____	
Cardiac Failure	☐	☐	_____	
Arrhythmia	☐	☐	_____	
Pacemaker / ACID Insitu / Stents	☐	☐	_____	
Other Conditions	☐	☐	_____	
RESPIRATORY	**YES**	**NO**	**Specify…**	**Family History ☐**
Tuberculosis	☐	☐	_____	
Asthma	☐	☐	_____	
Pneumonia / Bronchitis	☐	☐	_____	
Emphysema	☐	☐	_____	
Sleep Apnoea	☐	☐	_____	
Cough / Sputum	☐	☐	_____	
Smoker (Past or Current)	☐	☐	_____	
Other Conditions	☐	☐	_____	
METABOLIC / ENDOCRINE	**YES**	**NO**	**Specify…**	**Family History ☐**
Diabetes	☐	☐	_____	
Thyroid Disorder	☐	☐	_____	
Liver Disease	☐	☐	_____	
Other Condition	☐	☐	_____	

URINARY	YES	NO	Specify…	Family History ☐
Incontinency	☐	☐	_____	
Difficulty Passing Urine	☐	☐	_____	
Urgency / Frequency	☐	☐	_____	
Frequent UTI's	☐	☐	_____	
REPRODUCTIVE	**YES**	**NO**	**Specify…**	**Family History ☐**
Gynaecological Problems	☐	☐	_____	
Other Problems	☐	☐	_____	
If Female Currently Pregnant?	☐	☐	_____	
Currently Breastfeeding?	☐	☐	_____	
GASTROINTESTINAL	**YES**	**NO**	**Specify…**	**Family History ☐**
Incontinency (Faecal)	☐	☐	_____	
Stoma-ileostomy / Colostomy	☐	☐	_____	
Constipation	☐	☐	_____	
Irritable Bowel Syndrome	☐	☐	_____	
Diverticular Disease	☐	☐	_____	
Ulcerative Colitis / Crohns	☐	☐	_____	
Ulcers	☐	☐	_____	
Hiatus Hernia / Reflux	☐	☐	_____	
Other Conditions	☐	☐	_____	

BLOOD DISORDERS	YES	NO	Specify…	Family History ☐
Bleeding or Clotting Tendencies	☐	☐	_____	
Anaemia	☐	☐	_____	
Other Conditions	☐	☐	_____	
SKIN DISORDERS	**YES**	**NO**	**Specify…**	**Family History ☐**
Skin Disorder (Eczema / Psoriasis)	☐	☐	_____	

PSYCHOLOGICAL	YES	NO	Specify…	Family History ☐
Anxiety / Depression	☐	☐	_____	
Psychological Disorder	☐	☐	_____	

MUSCULOSKELETAL	**YES**	**NO**	**Specify…**	**Family History ☐**
Osteo / Rheumatoid Arthritis	☐	☐	_____	
Osteoporosis	☐	☐	_____	
Fractures	☐	☐	_____	
Soft Tissue Injuries	☐	☐	_____	
Gout	☐	☐	_____	
Bone Disease	☐	☐	_____	
Other Conditions	☐	☐	_____	

AUTOIMMUNE DISEASE	**YES**	**NO**	**Specify…**	**Family History ☐**
Speech / Swallowing Difficulties	☐	☐	_____	
Vision Impairment	☐	☐	Glasses ☐ Contacts ☐ Prosthesis ☐	
Hearing Impairment	☐	☐	Hearing Aid ☐ _____	
Language Spoken			_____	

IMUNISATIONS

	YES	**NO**	**Date Administered** (if known)
Childhood			
2 Months	☐	☐	___ / ___ / _____
4 Months	☐	☐	___ / ___ / _____
6 Months	☐	☐	___ / ___ / _____
12 Months	☐	☐	___ / ___ / _____
18 Months (born after 2012)	☐	☐	___ / ___ / _____
4 Years	☐	☐	___ / ___ / _____
Adult			
Tetanus	☐	☐	___ / ___ / _____
Flu Vax	☐	☐	___ / ___ / _____
Pneumonia	☐	☐	___ / ___ / _____
Cervical Vaccine	☐	☐	___ / ___ / _____